

**IN THE UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY
NEWARK VICINAGE**

Richard A. and Patricia Marsella
Individually and as p/g/n
of Richard J. Marsella,

Plaintiffs,

V.

American Airlines, United
HealthCare Services, Inc.,
United Health Group, Inc. and
John Does 1-10

Defendants.

Civil Action No.:
10-cv-1454-SDW-MCA

DECLARATION

ELECTRONICALLY FILED

I, Dale Ibitz, hereby declare as follows:

1. I am over eighteen (18) years of age and competent to testify.

The statements contained in this Declaration are based on my own personal knowledge, my review of the attached documents and are true and correct to the best of my knowledge.

2. I work on behalf of UnitedHealthcare Insurance Company (“UnitedHealthcare”) and its affiliate companies.

3. In my position, I am generally familiar with the manner in which UnitedHealthcare maintains its business records, including Summary Plan Descriptions ('SPDs') that employers, who contract with UnitedHealthcare to administer claims on their behalf under the employers' self-funded benefit plans, send to UnitedHealthcare to administer claims under those plans.

4. American Airlines, Inc. (the "Group") drafts its SPDs; not UnitedHealthcare. The Group has provided the Employee Benefits Guide for Flight Attendants of American Airlines and amendments to UnitedHealthcare as the true and correct copy of its SPD for the period of January 1, 2008, to December 31, 2008. Relevant pages from the SPD are attached as Exhibit "A."

5. Attached hereto as Exhibit "B" are true and correct copies of pages from the Point-of-Service Administrative Services Agreement between American Airlines, Inc. and UnitedHealthcare.

I declare that the foregoing statements are true and correct under penalty of perjury. Executed on July 12, 2010

Nate Selig

Exhibit A

Updated: 07/10/2007

AmericanAirlines®
Employee Benefits Guide
for Flight Attendants

About This Guide

This Employee Benefits Guide for Flight Attendants ("Guide") contains the legal plan documents and the summary plan descriptions (SPDs) for the following plans for Flight Attendants: the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (the "Group Life and Health Plan"), the Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (the "Supplemental Medical Plan"), the American Airlines, Inc. Long Term Disability Plan (the "LTD Plan"), and the Long Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries (collectively the "Plans").

The provisions of this Guide apply to eligible employees of the participating subsidiaries of AMR Corporation, including employees on the United States payroll, spouses, dependents, and surviving spouses who elect coverage under the benefits program for Flight Attendants.

In our efforts to provide you with full multimedia access to benefits information, American Airlines, Inc. has created online versions of the Plans and SPDs. If there is any discrepancy between the online version and this Guide, then the Plans contained in this Guide plus the official notices of changes to the Plans will govern.

The Company reserves the right to modify, amend or terminate any of the Plans, any program described in this Guide, or any part thereof, at its sole discretion. Changes to the Plans generally will not affect claims for services or supplies received before the change.

Only the Pension Benefits Administration Committee (PBAC) is authorized to change the Plans. From time to time, you may receive updated information concerning changes to the Plans. Neither this Guide nor updated materials are contracts or assurances of compensation, continued employment, or benefits of any kind.

In the event of a conflict between the Plans' provisions contained in this Guide and the provisions contained in any applicable collective bargaining agreement (and/or insurance policies for fully insured programs), the collective bargaining agreement (and/or insurance policy for fully insured programs) shall govern in all cases with respect to employees covered by such agreement.

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All four Standard Medical Benefit options offer a Medical Discount Program through a voluntary preferred provider organization (PPO). The PPO is a network of over 400,000 physicians, hospitals and other medical service providers that have agreed to charge discounted fees for medical services. Contact UnitedHealthcare at 800-638-9599 or log on to www.myuhc.com for more information about this program or to access a list of network providers.

For details on the Standard Medical Benefit Options, see page 5.

To see a comparison of your benefits under the Standard Medical Options and the Point-of-Service Option, see page 46.

Point-of-Service Option

The Point-of-Service Option ("POS Option"), administered by UnitedHealthcare, offers access to the network of physicians and hospitals that have agreed to provide medical services to plan participants at preferred rates. Each time you need medical care, you can choose to use a network or out-of-network provider, but you generally save money when you use a network provider.

When you use a network provider, you pay only a copayment or coinsurance for most services. You will also pay a \$50 per person annual deductible for hospital services and a \$50 per person annual deductible for prescription medications filled at network pharmacies.

When you use an out-of-network provider, the POS Option generally pays 70% of most services after you pay a \$500 per person annual deductible.

You can receive network benefits for specialist care without a referral from a primary care physician (PCP), but you are encouraged to have a PCP to coordinate network services for you. Contact United Healthcare at 800-545-9075 or log on to www.provider.uhc.com/american to review a list of network providers.

The POS Option is offered in most locations, but if you live outside the UnitedHealthcare access area, you are not eligible for the POS Option and must choose one of the four Standard Medical Options or an HMO for medical coverage. For details on the POS Option, see page 76.

To see a comparison of your benefits under the Standard Medical Options and the POS Option, see page 46.

Health Maintenance Organizations (HMOs)

HMOs provide medical care through a network of physicians, hospitals and other medical service providers. You must use network providers to receive coverage under the HMO. Your expenses, including prescription drugs and mental health care, are covered according to the rules of the HMO you select.

Most HMOs require you to choose a primary care physician (PCP) to coordinate your medical care and to obtain a referral from your PCP before receiving care from a specialist.

HMOs are offered in many locations, based on your home ZIP code, and vary by location. For a listing of HMOs currently offered, see page 84. HMOs offered in your area appear as options in the Benefits Enrollment Center on *Jetnet* during enrollment. When you enroll in an HMO, you will receive detailed information directly from that HMO.

For more details about HMOs, see page 83.

Medical Benefit Options

Overview

The Company offers eligible employees the opportunity to elect medical coverage that provides protection for you and your covered dependents in the event of illness or injury. You may choose from several medical options offered to American Airlines employees who are Flight Attendants, including Health Maintenance Organization (HMO) providers, or you may waive coverage completely if you have other coverage.

Some options may not be offered in all locations. During enrollment periods (as a new employee when you are first eligible for benefits, during the annual enrollment period), or if you experience a qualifying Life Event, your Benefits Enrollment Center on *Jetnet* will reflect the options that are available to you.

- The Standard Medical Options and the Point-of-Service Option are self-funded by the Company. UnitedHealthcare (UHC) administers these options; however, reimbursements for covered health care expenses are paid from the general assets of the Company, not by an insurance company.
- HMOs are insured options whose covered services are paid by the HMO. The Company pays a flat monthly premium and the HMO pays for all covered services. HMOs are offered in many locations, but their coverage and features vary by location. If you live in a location where an HMO is offered, it will be indicated as an option when you enroll online.
- You may waive coverage, if you are covered under another plan (such as your spouse's employer-sponsored plan). Your dependents cannot have coverage if you are not covered. You will not be able to file claims under a medical option of any AMR subsidiary if you waive coverage. You will not be able to enroll in coverage during the year unless you experience a qualified Life Event (see page 34).

Refer to page 13 for details regarding eligibility for benefits, dependent coverage, and employees married to other employees.

Key Features of the Standard and Point-of-Service Options

The following are key features of the Standard Medical Options and the Point-of-Service (POS) Option. Refer to the *Covered Expenses* section of this guide (see page 58) for a list of specific covered expenses.

Medically necessary: Medical care is covered by the Standard Medical Options when the care is medically necessary, it is an Eligible Expense, and it is not excluded from coverage. The Standard Medical Options also cover well-child care (up to age two) and periodic mammograms. Under the POS Option, the same medically necessary requirements apply. However, some services, such as routine physical exams and preventive care, are covered when you use a network provider. Please note that just because a physician orders a service does not mean the service is medically necessary.

Usual and prevailing fee limits: The amount of benefits paid for eligible expenses is based on the usual and prevailing fee limits for a particular service or supply in that geographic location. Because participating providers in the Standard Medical Options' Medical Discount Program (also referred to as the Preferred Provider Organization or PPO) and the POS Option's network providers have agreed to discounted fees, the usual and prevailing fee limits do not apply.

Plan Administration

Plan Information

The Plans listed below are sponsored by American Airlines, Inc. as that term is defined under ERISA Section 3(16)(B).

Plan Name	Plan Number
The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries This plan includes: <ul style="list-style-type: none"> • Medical Benefits <ul style="list-style-type: none"> – Standard Medical Option – Point-of-Service Option – Health Maintenance Organizations • Dental Benefits (Active Employees) <ul style="list-style-type: none"> – Dental Option 1 – Dental Option 2 • Employee Term Life Insurance Benefits • Accidental Death & Dismemberment Insurance Benefits • Terrorism & Hostile Action Accident Insurance Benefit • Special Purpose Accident Insurance Benefit • Optional Short Term Disability Insurance Benefit (effective January 1, 2004) • Spouse and/or Child Term Life Insurance Benefits • Vision Insurance Benefit (effective January 1, 2004) • Health Care Flexible Spending Account Benefit • Dependent Day Care Flexible Spending Account Benefit • Voluntary Personal Accident Insurance Benefit • Prefunding of Retiree Medical Benefits • Retiree Medical Benefits (see Retiree Benefits Guide) 	501
The Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries	503
American Airlines, Inc. Long Term Disability Plan	509
Long Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries	510
American Airlines, Inc. Retiree Dental Insurance Plan (see Retiree Benefits Guide)	512

Administrative Information

American Airlines, Inc.

(See below)

Plan Sponsor and Administrator

American Airlines, Inc.

Mailing address:

Mail Drop 5141-HDQ1

P.O. Box 619616

DFW Airport, TX 75261-9616

Street address (do not mail to this address):

4333 Amon Carter Blvd.

Fort Worth, Texas 76155

The Plan Administrator for Second Level Claim Appeals

Pension Benefits Administration Committee (PBAC)

American Airlines

MD 5134-HDQ1

P.O. Box 619616

DFW Airport, TX 75261-9616

Agent for Service of the Legal Process

Managing Director, Benefits and Productivity

American Airlines, Inc.

Mailing address:

Mail Drop 5126-HDQ1

P.O. Box 619616

DFW Airport, TX 75261-9616

Express Delivery address:

4333 Amon Carter Blvd.

Fort Worth, TX 76155

Claims Processor

The claims processors for each benefit or plan vary and are listed in *Contact Information* on page 1.

Trustee

The Trustee for the American Airlines, Inc. Health Benefits Trusts (prefunding trusts), the American Airlines, Inc. Supplemental Medical Benefits Trusts, and the American Airlines, Inc. Long Term Disability Plan Trust is:

State Street Bank & Trust

200 Newport Avenue

North Quincy, Massachusetts 02171

Employer ID Number

13-1502798

Plan Year

January 1 through December 31

Participating Subsidiaries

American Airlines, Inc.

American Eagle, Inc.

Plan Amendments

The Pension Benefits Administration Committee (PBAC), under the authority granted to it by the Board of Directors through the Chairman, has the sole authority to interpret, construe, determine claims, and adopt and/or amend employee benefit plans ("Plans"). The PBAC, in consultation with actuaries, consultants, Employee Relations, Human Resources, and the Legal Department, has the discretion to adopt such rules, forms, procedures, and amendments it determines are necessary for the administration of the Plans according to their terms, applicable law, regulation, collective bargaining agreements, or to further the objectives of the Plans. The PBAC may take action during a meeting if at least half the members are present or by a unanimous written decision taken without a meeting and filed with the Chairman of the PBAC.

The administration of the Plans shall be under the supervision of the Plan Administrator. The Employer hereby grants the PBAC the authority to administer and interpret the terms and conditions of the Plans and the applicable legal requirements related thereto. It shall be a principal duty of the PBAC to see that the administration of the Plans is carried out in accordance with its terms, for the exclusive purpose of providing benefits to Participants and their beneficiaries in accordance with the documents and instruments governing the Plans. The PBAC will have full power to administer the Plans in all of their details, subject to the applicable requirements of law. For this purpose, the PBAC's powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by the Plans:

- To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plans, including the establishment of any claims procedures that may be required by applicable provisions of law and to request extension of time periods hereunder and request additional information
- To interpret and construe the terms of the Plans, their interpretation thereof in good faith to be final and conclusive upon all persons claiming benefits under the Plans
- To decide all questions concerning the Plans, and to determine the eligibility of any person to participate in or receive benefits under the Plans and to determine if any exceptional circumstances exist to justify any extensions
- To compute the amount of benefits that will be payable to any Participant or other person, organization or entity, to determine the proper recipient of any benefits payable hereunder and to authorize the payment of benefits, all in accordance with the provisions of the Plans and the applicable requirements of law
- To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plans

- To allocate and delegate its responsibilities under the Plans and to designate other persons to carry out any of its responsibilities under the Plans, any such action to be by written instrument and in accordance with ERISA Section 405
- To delegate its authority to administer Claims for benefits under the Plans by written contract with a licensed third party administrator, and
- To the extent permitted by law, to rely conclusively upon all tables, valuations, certificates, opinions and reports that are furnished by accountants, counsel or other experts employed or engaged by the PBAC.

Plan Funding

The coverage for the following benefits is self-funded through both Company and employee contributions:

- Standard Medical Options
- Point-of-Service Option
- Dental Benefits (Active Employees)
- Retiree Medical Benefits

The Supplemental Medical Plan and the Long Term Disability Plan are self-funded through employee contributions. Health Maintenance Organizations (HMOs) are fully insured and are funded through both Company and employee contributions.

Employee contributions as plan assets are held in Voluntary Employee Benefit Association (VEBA) trusts established under Section 501(c)(9) of the Internal Revenue Code. Self-funded benefits are paid from trust assets. The claims processors are independent companies that provide claim payment services. They do not insure these benefits.

Coverage for the following benefits is fully insured and premiums are paid by the Company:

- Basic Term Life Insurance Benefit
- Basic Accidental Death & Dismemberment Insurance Benefit
- Special Purpose Accident Insurance Benefit
- Terrorism & Hostile Action Accident Insurance Benefit

The following benefits are fully insured and paid entirely by employee contributions:

- Voluntary Personal Accident Insurance Benefit
- Optional (Contributory) Levels of Employee Life Insurance Benefit
- Spouse and/or Child Term Life Insurance Benefit
- Optional Short Term Disability Insurance Benefit
- Retiree Dental Insurance Plan
- Vision Insurance Benefit
- Long Term Care Insurance Plan

Effect of Failure to Submit Required Claim Information

If the claims processor determines you failed or refused to comply in a timely manner with any reasonable request for information in connection with your claim (including, but not limited to, claim forms, medical examinations, medical information or reports and appropriate medical information release forms) you shall be deemed to have abandoned your claim for benefits as of the date you fail or refuse to comply and you shall not be entitled to any further benefits. However, your claim shall be reinstated upon your compliance with the claims processor's request for information or upon a demonstration to the satisfaction of the claims processor that under the circumstances the claims processor's request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the claims processor, taking into consideration the cause or reason for your failure or refusal, the length of the period, and other facts or circumstances the claims processor deems relevant.

Appealing a Denial***Procedures for Appealing an Adverse Benefit Determination***

American Airlines, Inc., as Sponsor and Administrator for the Company-sponsored health and welfare benefit plans, has a two-tiered appeal process — referred to as First Level and Second Level Appeals. First Level Appeals are conducted by the claims processor or benefit administrator that rendered the adverse benefit determination. Second Level Appeals are conducted by the Pension Benefits Administration Committee (PBAC) at American Airlines, Inc.

This two-tiered appeal process applies to adverse benefit determinations made on all self-funded benefits or plans, as follows:

- Medical Benefits (including prescription drug coverages/options)
- Dental Benefits
- Supplemental Medical Plan
- Retiree Medical Benefits
- Flexible Spending Account Benefits
- Long Term Disability Plan,

and for administrative, eligibility, and enrollment issues on any and all benefits or plans offered through the benefits program for Flight Attendants.

With respect to adverse benefit determinations made on fully insured benefits, as follows:

- Term Life Insurance Benefit (Employee, Spouse, and Child)
- Accidental Death & Dismemberment Insurance Benefits (Employee, Spouse, Child, VPAI, and all Company-provided accident insurance benefits)
- HMOs
- Optional Short Term Disability Insurance Benefit
- Long Term Care Insurance Plan
- Retiree Dental Insurance Plan,

Exhibit B

Point-of-Service Administrative Services Agreement

Effective January 1, 2001

between

**American Airlines, Inc.
("American")**

and

**United HealthCare Insurance Company
("United HealthCare")**

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THIS POINT-OF-SERVICE ADMINISTRATIVE SERVICES AGREEMENT (the "Agreement") is effective commencing January 1, 2001, by and between American Airlines, Inc. ("American") a Delaware corporation, having an address at 4333 Amon Carter Boulevard, Fort Worth, Texas 76155, and United HealthCare Insurance Company ("United HealthCare"), a Connecticut corporation, having an address at 450 Columbus Boulevard, Hartford, Connecticut 06115-0450. Capitalized terms used herein and not defined in the body of this Agreement shall have the meaning assigned to such terms in Article I hereof.

Recitals

WHEREAS, American has established and maintains one or more benefit plans to provide medical benefits to certain current and former employees, dependents and beneficiaries of such employees, and certain other persons, for which benefit plans American serves as the Plan Administrator; and

WHEREAS, American represents that it is the Plan Administrator and named fiduciary within the meaning of those terms under ERISA for The Group Life and Health Benefits Plan for Employees of participating AMR Corporation Subsidiaries, as more fully described in Article I, Section 27 of this Agreement defining the term "Plan"; and

WHEREAS, American's Plan will include a Point-of-Service (POS) program as a major component; and

WHEREAS, American requires the expertise of a knowledgeable provider and administrator of POS Network Services, benefits and products to provide and administer POS network and medical management Services as hereinafter defined; and

WHEREAS, United HealthCare represents that it is a knowledgeable provider and experienced administrator of POS networks and medical management Services and products; and

WHEREAS, United HealthCare has indicated to American that it desires to perform the Services as specified in this Agreement; and

WHEREAS, American as Plan Administrator for the plan has established one or more voluntary employee benefit association (VEBA) trusts within the meaning of Section 501(c)(9) of the Internal Revenue Code of 1986, as amended, to provide for payment of health care benefits under the Plan, the trustee of which, as of the date of this Agreement, is State Street Global Advisors, a banking corporation; and

WHEREAS, American represents that during the term of this Agreement, it is authorized to act on its own behalf and on behalf of the above named Plan.

NOW, THEREFORE, in consideration of the mutual covenants and agreements set forth in this Agreement, the parties hereby agree as follows:

Article III — Obligations of American

1. American will provide United HealthCare with the statistics and other information which United HealthCare may need to perform Services under this Agreement in such forms and at such intervals as are mutually acceptable to American and United HealthCare.
2. American will make every reasonable effort to provide United HealthCare with adequate advance written notice of Plan Changes. American will provide United HealthCare with copies of the Summary Plan Descriptions which are attached (Appendix D) to this Agreement.
3. In determining any person's right to benefits under the Plan, United HealthCare shall be entitled to rely upon eligibility information furnished by American or any independent contractor designated by American. American will advise United HealthCare on a timely basis during the continuance of this Agreement of the identity of individuals eligible to participate in the POS Program. Such information shall identify the Effective Date of eligibility and the termination date of eligibility and shall be provided promptly to United HealthCare in a form and with such other information as may reasonably be required by United HealthCare for the proper administration of the Plan. In no event will United HealthCare be liable for Overpayments that arise from incorrect eligibility information furnished by American or any independent contractor American designates to provide eligibility on behalf of the Plan.
4. The liability for Plan benefits paid under the Plan is always the obligation of the Plan. If Plan benefits are paid as a consequence of litigation, United HealthCare is authorized to pay such benefits by draft(s) drawn against the Special Bank Account described in Article X of this Agreement. If, however, United HealthCare pays Plan benefits from its own funds in accordance with Appendix F, Section 4, American will reimburse United HealthCare. The terms of this Article III, Section 4 shall not apply to Overpayments for which United HealthCare is obligated to indemnify the Plan pursuant to Article V, Sections B or C herein.
5. American shall supply United HealthCare with a list of American's Affiliated Employers, if any, prior to United HealthCare commencing the Services United HealthCare is providing under this Agreement.

American must give United HealthCare prior written notice of any changes to the list of Affiliated Employers whose Employees are Covered by the Plan. American represents the following about American and their Affiliated Employers: subject to ERISA, American and the Affiliated Employers together make up a single "control group" as defined in Section 3(40)(B) of ERISA.